The influence of the mother's age upon the sex of the child is discussed by AHLFELD (*Monatsschrift f. Geburtshülfe und Gynäkologie*, 1912, Band xxxvi, Heft 3). He believes that the proportion of male births to female increases, when the mother at the time of her first labor is either considerably below, or considerably above the average age of child-bearing.

LUTZ (*Zentralblatt f. Gynäkologie*, 1913, No. 4), presents in tabular form the characteristics of 24 infants born at nine months' gestation. The term "ripe" and "fully developed" are applied so loosely to the infant that it is necessary to have a number of points upon which to base the opinion that the child is fully developed. He would apply the term "fully developed" to a child born from thirty-nine to forty-one weeks after the first day of the last period. The term "ripe" should be limited to those children in whom development was equally advanced in all the essential points. He draws attention to the fact that an infant may be born in forty weeks after the last period and still lack some of the signs of maternity, while other children born in thirty-two weeks may seem to be fully grown. The weight, length, and the circumference of the cranium are important. The statistics indicate that at the end of the eighth month the child should weigh 2050 grams, the length should be 48 cm., and the cranial circumference 34 cm. At the ninth month 2880 grams, length 52 cm., cranial circumference 35 cm. At the tenth month, weight 3310 grams, length 54 cm., circumference of head 37 cm. Of the 24 cases cited, but three were less than 50 cm. in length.

GYNECOLOGY

UNDER THE CHARGE OF

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Endometritis and Uterine Hemorrhage.—Although the trend of modern opinion is for the most part away from the old idea that endometritis is of itself ever the real cause of excessive uterine hemorrhage, DRIESSEN (*Zentralbl. f. Gyn.*, 1914, xxxviii, 618) believes that there is one very definite type of endometritis which does stand in this relation to metrorrhagia. He also, in contradistinction to some modern authors, maintains the correctness of the older view that at each menstrual period actual bits of the surface mucosa are cast off and discharged from the uterus; this he has proved by carefully collecting and examining the menstrual blood. He believes that this occurs in the following way: In the premenstrual stage the endometrium becomes differentiated into two layers, a compact and a spongy. The former, and part of the latter, undergo necrosis, accompanied by an invasion of polymorphonuclear leukocytes. Numerous small bloodvessel ruptures, with consequent hemorrhages, occur; these hemorrhagic areas then become organized by the ingrowth of young fibroblasts. The necrotic portions are cast off, and the newly formed stroma is covered with a new epithelium, whose cells show active proliferation. This is the normal process, and is associated with normal ovarian activity. In some cases of irregular menstruation, however, associated with an insufficiency of ovarian function—a condition that is especially apt to occur about the time of puberty or the menopause—the necrotic portions of the old endometrium are not cast off, but remain attached to the surface, just as bits of placental tissue remain after an incomplete abortion. As a result of this, Driessen thinks, a peculiar type of endometritis arises, which may be the cause of profuse hemorrhages. Pathologically, this type of endometritis is characterized by the occurrence here and there in the stroma of *hyaline masses*, the result of non-organized hemorrhages; these are always surrounded by masses of leukocytes. The glands may show some cystic dilatation, and the epithelium may be multilayered, almost suggesting malignancy. It is evident, Dreissen thinks, that the presence of these hyaline and necrotic masses, acting as foreign bodies, causes the active inflammatory infiltration of the endometrium, and that the incomplete regeneration of the stroma causes compression of the gland outlets and dilatation of the deeper portions. Just as bleeding after an abortion does not cease until the placental remains are removed from the endometrium, so the menstrual bleeding associated with this type of endometritis persists until either the incompletely cast off necrotic areas are removed by curettage, or the ovarian function is completely destroyed by oöphorectomy or the *x*-ray. For the majority of these patients, Driessen considers the last named method of treatment the most satisfactory.

Amniotic Membrane for the Prevention of Postoperative Adhesions.—Undoubtedly one of the most difficult problems encountered by the abdominal and pelvic surgeon is the prevention of adhesions between peritoneal surfaces from reforming after their separation, or from occurring after operations in infected areas. Many forms of artificial and animal membranes, oils, etc., have been tried, with practically no result. An interesting suggesting is now made by LYMAN and BERGTOLD (*Surg., Gyn., and Obst.*, 1914, xviii, 762) to use human amniotic membrane for this purpose. It appears to have several distinct advantages, in that it is easy to obtain in sheets of large size, it is originally sterile, can be easily preserved and kept sterile, and is thin, easy to handle, and is probably easily absorbed. Lyman and Bergtold report its use in seven cases, with very gratifying results; one of the patients was a young woman who had been operated upon twice for the relief of adhesions throughout the abdomen, without benefit. A third operation was performed, with free use of the membrane, and was followed by complete relief of the symptoms, a condition which has lasted for over five months since operation. The amniotic membrane is obtained from a patient free from constitutional disease; it is prepared by washing in running water for two hours, and is then preserved until wanted in a 0.5 per cent. solution of formaldehyde in 70 per cent. alcohol.